STUDY AND EVALUATION OF THE EFFECTIVENESS OF MENTAL HEALTH CONSUMER ENROLLMENT AND MEDICATION ACCESS

(FY2007 Appropriation Bill - Public Act 330 of 2006)

September 30, 2007

Section 1628: (1) The department shall convene by April 2007 a committee to study the implementation of psychotropic pharmacy administration under Medicare part D for individuals dually enrolled in the Medicare and Medicaid programs. This committee shall study and evaluate the effectiveness of mental health consumer enrollment and medication access through the Medicare part D procedures for pharmaceutical management for dual eligibles. (2) The committee shall include a representative from each of the following organizations: the medical services administration, the office of services to the aging, the department's mental health and substance abuse services division, mental health association of Michigan, national alliance for the mentally ill of Michigan, Michigan psychiatric society, Michigan association of community mental health boards, Michigan pharmacists association, Michigan protection and advocacy service, international association of psychosocial rehabilitation services, and the pharmaceutical industry. The committee shall elect a chairperson who is not employed by state government. (3) The committee shall produce a report by September 30, 2007 to the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor
Janet Olszewski, Director

Michigan Department of Community Health

Mental Health Pharmacy Services For Dual Eligibles Under Medicare Part D

A Report to the House and Senate Appropriations Subcommittees on Community Health

December 2006

ACKNOWLEDGEMENTS

We acknowledge and thank the Medicare Part D committee members from the Mental Health Association in Michigan, the Michigan Association of Community Mental Health Boards, the Michigan Pharmacists Association, the Michigan Protection and Advocacy Services, the Michigan Psychiatric Society, the National Alliance on Mental Illness of Michigan, and the Wayne State University Department of Psychiatry and Behavioral Neurosciences who took the time to participate in committee discussions, review survey results, analyze data, and offer feedback to the Michigan Department of Community Health.

Special thanks go to Richard Berchou, Pharm. D., from Wayne State University who agreed to chair the committee; to Mark Reinstein of the Mental Health Association in Michigan who organized a workgroup to develop a survey instrument to compile Community Mental Health Services Program (CMHSP) experiences with Part D; and to the Michigan State University Institute for Health Care Studies who coordinated committee meetings, retrieved Part D data on the dual eligibles, and surveyed Community Mental Health Services Programs on the Part D's impacts for their consumers.

Executive Summary

On January 1, 2006, most prescription drug coverage for 6.2 million individuals dually enrolled in Medicaid and Medicare (the dual eligibles) across the nation – including nearly 200,000 in Michigan – was transitioned from Medicaid to the Medicare prescription drug benefit. Within days, problems occurred that made it difficult for some dual eligibles to obtain needed prescription drugs.[1] Problems occurring in Michigan were addressed by staff from the Michigan Department of Community Health (MDCH) and from the Centers for Medicare and Medicaid Services (CMS) at the federal level. The transition for dual eligibles was also eased by extraordinary efforts from frontline workers in pharmacies, local community mental health agencies, the Michigan Medicare/Medicaid Assistance Program, senior centers, and many other organizations.

Section 1628 of Public Act 154 of 2004 stipulated that MDCH organize a committee to study the impact of the Part D transition on dual eligibles receiving psychotropic drugs. MDCH is submitting this report to the members of the House and Senate Subcommittees on Community Health and the House and Senate fiscal agencies in compliance with Section 1628. The committee observations and findings include:

- Almost 50 percent of the dual eligibles in Michigan received psychotropic medications under the Medicaid program during the last six months of calendar 2005.
- Over 190,000 Michigan full-benefit dual eligibles were enrolled in Medicare prescription drug plans during June 2006.
- The majority of dual eligibles are currently receiving their prescription drugs, including psychotropic medications, in a timely manner. However, mental health providers continue to note challenges navigating the numerous Part D formularies, utilization controls, and prior authorization requirements.
- Many desired enhancements to Medicare Part D discussed by the committee members would require amendments to the Medicare Modernization Act of 2003 and would likely not be easily accomplished.
- About 2,600 dual eligibles were not enrolled in a Medicare prescription drug plan. Committee members noted non-enrollment counts for a given month may fluctuate because of retroactive Medicare eligibility; changes in other credible prescription drug coverage; and federal government processing delays to assign dual eligibles to a plan. CMS has implemented a Point-Of-Sale (POS) Facilitated Enrollment Process to provide needed prescriptions for non-enrolled dual eligibles. While this remedy may protect dual eligibles, the committee members believe the department should continue to closely monitor individuals who have not been enrolled.

[1] V. Smith, K. Gifford, S. Kramer, and L. Elam, The Transition of Dual Eligibles to Medicare Part D Prescription Drug Coverage: State Actions During Implementation, Results from a 50-State Snapshot, Kaiser Commission on Medicaid and the Uninsured, February 2006, available at www.kff.org

I. BACKGROUND

A. Appropriation Act Requirements at Section 1628

The Michigan Department of Community Health (MDCH) is submitting this report to comply with provisions at Section 1628 of Public Act 154 of 2005, which stipulate:

- MDCH must convene by April 2006 a committee to study and evaluate "psychotropic pharmacy administration" under Medicare Part D for individuals dually enrolled in the Medicare and Medicaid programs (the dual eligibles).
- The committee will study and evaluate the effectiveness of mental health consumer enrollment and medication access through Medicare Part D procedures.

B. Medicare Part D and Dual Eligibles

The Medicare Modernization Act[2] adopted in December 2003 added a Part D prescription drug program to Medicare coverages beginning 2006 (Table 1). With this addition the following significant changes for the dual eligibles also occurred.

Table 1: Medicare Program	
Part A	*Hospital insurance* for inpatient stays, some skilled nursing facility care, hospice care, and home health care
Part B	*Medical insurance* for doctor services, outpatient hospital care, durable medical equipment, some medical supplies and drugs
Part C	*Medicare Advantage* – previously called Medicare+Choice – for Parts A and B benefits (and may include prescription drug coverage) provided by private, at-risk health plans
Part D	*Prescription drug benefit,* which started January 1, 2006 and includes cost-sharing and premium subsidies for beneficiaries with low-incomes.

- Starting January 1, 2006 the Medicare Modernization Act requires dual eligibles to receive most drug coverage from Medicare not Medicaid. (This change affected about 190,000 full-benefit dual eligibles[3] in Michigan and 6.2 million nationally.) Other healthcare coverages for the dual eligibles remained under Medicaid.
- Even though full-benefit dual eligibles were transitioned to Medicare Part D, the Medicare Modernization Act requires states to help finance the cost of their drugs provided by the Medicare plans. States send monthly per-capita payments (often called *clawback*) to the federal government for each dual eligible enrolled in a Medicare prescription drug plan. The clawback's formula is complex. It is based on a state's share of historical payments from 2003, inflated to 2006 using a national growth rate, and then indexed by growth in actual Part D spending for following years. The federal government takes backs 90 percent of the calculated clawback amount in 2006 and then tapers down to 75 percent for 2015 and thereafter.
- Starting January 1, 2006 states no longer receive federal Medicaid matching funds on most prescription drug costs for the full-benefit dual eligibles. An exception is that states may continue to receive federal Medicaid matching funds for reimbursing drugs that cannot be

[2] Formally called *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003,* Public Law 108-173
[3] "Full-benefit" dual eligibles previously received Medicaid prescription drug coverage and other healthcare services. The state also has dual eligibles enrolled in Medicare Savings Program who receive coverage for Medicare premiums or cost-sharing, but no other Medicaid service. Under the Medicare Modernization Act, Medicare Savings Program dual eligibles qualify for Part D low-income subsidies on premiums and cost-sharing and for CMS facilitated enrollment into Part D plans that started May 2006 and monthly thereafter.

covered by the new Medicare plans. Examples, which Michigan Medicaid covers under this exception, are selected Part B drugs, benzodiazepines, barbiturates, agents used to promote smoking cessation, prescription vitamins/mineral products, and over-the-counter drugs.

- Each Medicare Part D plan has flexibility to develop its own coverages and utilization controls for prior authorization, step therapy (or fail-first policy where another drug must be tried before another is authorized), quantity/frequency limits, etc. for Part D covered drug classes. CMS also issued guidance that required plans to cover *all or substantially all* of six protected drug categories: antidepressants, antipsychotics, anticonvulsants, antiretrovirals (HIV/AIDS), immunosuppressants, and antineoplastics (anticancer). This guidance, however, does not prohibit the Medicare prescription drug plans from implementing utilization controls on these drug classes, e.g. quantity and frequency limits.
- Full-benefit dual eligibles qualify for cost-sharing subsidies based on their income as a percentage of the federal poverty level (FPL). For example, during calendar year 2006, their prescription copayments could not exceed $1 for generics and $3 for brands below 100% FPL and $2 for generics and $5 for brands at or above 100% FPL.[4] Dual eligibles residing in nursing homes and other institutions have no cost-sharing after they have been institutionalized for 30 days.[5] Dual eligibles, also, do not have a gap in drug coverage (often called the donut hole) that applies to other Medicare beneficiaries.
- During 2006 eighteen stand-alone companies offered forty different Medicare Part D plans to Michigan Medicare beneficiaries. Monthly premiums are totally subsidized when a dual eligible is enrolled with a Medicare Part D plan whose premium meets a low-income subsidy benchmark set by CMS. Fourteen of the forty Michigan stand-alone Part D plans met this benchmark during 2006. Dual eligibles who choose to enroll in plans other than these fourteen must pay the amount that their plan's premium is over the low-income subsidy benchmark.
- Unlike other Medicare beneficiaries, dual eligibles may enroll with a Part D plan or switch from plan-to-plan monthly. To assist the dual eligibles who do not select their own plan CMS auto-assigns them randomly into Medicare Part D plans.
- Once enrolled in Medicare Part D, dual eligibles continue to qualify for Medicare Part D benefits for the remainder of the calendar year – even if Medicaid eligibility is lost. At the end of each year CMS will re-determine whether an individual still qualifies automatically for another year of Part D coverage as a dual eligible.

Part D Auto-Enrollment for Dual Eligibles

The Medicare Modernization Act authorized CMS to auto-assign dual eligibles into plans meeting the low-income subsidy (LIS) benchmark – fourteen plans in Michigan during 2006. CMS uses state eligibility files generated monthly by the department to randomly assign the dual eligibles to the fourteen plans. The first auto-assignment process occurred the fall of 2005. For this massive enrollment and for subsequent months thereafter for new dual eligibles, CMS sends dual eligibles an auto-enrollment notice[6] that explains:

[4] Dual eligible copayments are indexed annually. Starting January 1, 2007, the amounts will be set at $1 for generics and $3.10 for brands below 100% FPL and $2.15 for generics and $5.35 for brand at or above 100% FPL.
[5] Residents in assisted living and ICF-MR facilities, however, do not qualify for the copayment exemption.
[6] The full auto-enrollment notice is available at: www.cms.hhs.gov/States/Downloads/AutoEnrollmentNotice.pdf

"Medicare will help pay for your prescription drugs instead of Medicaid. If you continue to be eligible for Medicaid, Medicaid will still pay for your health care costs that Medicare doesn't cover."

"To get Medicare prescription drug coverage, you need to join a Medicare drug plan. Medicare is enrolling you in <***Organization's name***>'s <***Name of plan***> and your coverage began <***auto-enrollment effective date***>."

"If you would like to switch to a different Medicare drug plan, call 1-800-MEDICARE (1-800-633-4227) for a list of the prescription drug plans with no premium …"

"If you don't want to join, and you don't want Medicare to enroll you in a Medicare drug plan, call 1-800-MEDICARE and tell them you don't want to join. But, keep in mind that you pay nothing to stay in the plan. If you drop this coverage and need prescription drugs, Medicaid will not pay for them, and Medicare won't pay until you join a plan."

"…if you tell Medicare you don't want to join a Medicare drug plan, you could have no prescription drug coverage. You can change your mind and join a Medicare drug plan at any time, but you may have to pay a penalty to join later."

Initial Transition Problems for the Dual Eligibles

Within days of the dual eligibles' transition from Medicaid to Medicare Part D on January 1, 2006, problems occurred across the nation that made it difficult for some to obtain needed prescription drugs (Table 2). In Michigan, the transition for dual eligibles was eased by the extraordinary efforts of pharmacies, local community mental health agencies, senior centers, the Michigan Medicare/Medicaid Assistance Program, and many other organizations. MDCH staff also spent countless hours validating the accuracy of data files used for the CMS Part D auto-enrollment and developing interfaces that allowed the department's real-time, online payment systems to display Medicare plan assignments to pharmacies. Surfacing issues were addressed on a case-by-case basis by MDCH staff. Others were resolved by federal remedies including the following corrective actions.

Table 2: Initial Part D Transitional Issues

For Dual Eligibles	*For Pharmacies Serving Dual Eligibles*
Not being auto-assigned to a Part D plan	Being unable to obtain correct information necessary to bill the Part D plans
Being auto-assigned to 2 plans	Experiencing difficulties contacting the Part D plan helpdesks or federal help line
Being assigned to a plan operating in another state	Receiving misinformation from Part D plans and the federal government
Being incorrectly charged cost-sharing amounts or month premiums	Being unable to identify which drugs were covered by Medicare Part B versus Part D
Being unable to obtain drugs that had previously been covered by Medicaid	Finding some Part D plans were not adhering to federal requirements to supply a 30-day supply of drugs not on a plan's preferred drugs list or not covering *all of substantially all* drugs in the six protected drug categories.

Source: V. Smith, K. Gifford, S. Kramer, and L. Elam, The Transition of Dual Eligibles to Medicare Part D Prescription Drug Coverage: State Actions During Implementation, Results from a 50-State Snapshot, Kaiser Commission on Medicaid and the Uninsured. February 2006. available at www.kff.org

- Increased the accuracy and timeliness of data exchanges with Part D plans and its contractor charged with processing real-time eligibility transactions
- Expanded the CMS help desk staff from 150 to 4500 representatives and requested that Part D plans increase their call line capacity

- Asked Medicare Part D plans to pay the first-fill (and two additional 30-day prescriptions until March 31, 2006) of non-preferred drugs to allow pharmacies and physicians time to coordinate necessary prescription changes or request exceptions to plan coverages
- Required Medicare Part D plans to implement expedited approval of the $1/$3 or $2/$5 copayments which apply to dual eligibles based on information provided by pharmacies
- Contracted with a vendor (Wellpoint) to assist dual eligibles enroll with a Part D plan and receive needed medications – when they were not yet assigned a Part D plan or a Part D plan assignment could not be determined at the pharmacy counter

January 2007 Issues

The Medicare Modernization Act mandates annual re-procurement of the Part D plans' contracts. With this mandate, changes are likely in the number of participating companies and in their plan options qualifying for the low-income subsidy benchmark (with its zero premium for dual eligibles). After the committee's last meeting, CMS announced the 2007 participating Medicare Part D plans. Preliminary analysis shows that several of the current fourteen plans will no longer provide zero Part D premiums for Michigan dual eligibles in 2007.

CMS has provided states the following guidance on its procedures to *re-deem* dual eligibles for the upcoming calendar year 2007 or to *reassign* them to plans offering zero premiums for dual eligibles.

- Dual eligibles – whose current plans have premiums that exceed the 2007 low-income subsidy benchmark by $2 or more or whose plans are terminating – will be reassigned to another plan which qualifies for the benchmark offered by the same company. If no such plan exists, CMS will reassign dual eligibles randomly among other companies' plans qualifying for the low-income benchmark. CMS notified dual eligibles of their reassignments in early November 2006.
- Dual eligibles will not be reassigned, if they elected a plan other than the one assigned to them by CMS in 2006 – regardless of that plan's premium.
- Medicare beneficiaries who have attained Medicaid eligibility some time during July through December 2006 – even for a day – will be deemed eligible for Part D low-income subsidies as dual eligibles for the entire 2007 calendar year.
- Medicare beneficiaries – who (1) previously were deemed dual eligibles for purposes of 2006 Part D coverages *and* (2) who were not eligible for Medicaid during July 2006 – were sent notices of their ineligibility for Part D low-income subsidies as a dual eligible. Some of these individuals may qualify for other Part D low-income subsidies and the CMS notice encouraged them to complete an enclosed application for these subsidies.

II. MICHIGAN'S MEDICARE PART D COMMITTEE

MDCH convened a committee to study Part D's impact on dual eligibles receiving psychotropic medications. Its membership (Appendix A) consisted of a cross section of the industry including the Mental Health Association in Michigan, the Michigan Association of Community Mental Health Boards, the Michigan Pharmacists Association, the Michigan Protection and Advocacy Services, the Michigan Psychiatric Society, the National Alliance on Mental Illness of Michigan, the Department of Psychiatry and Behavioral Neurosciences from Wayne State University, and Michigan State University Institute for Health Care Studies. Department staff from the Michigan Medicare/Medicaid Assistance Program, the Office of Services to the Aging, Mental Health and Substance Abuse Administration, and Medical Services Administration also participated in the committee. Four committee meetings were held during April through September 2006.

A. Committee Objectives

The committee's primary objectives were to study and evaluate Medicare Part D's impact on dual eligibles receiving psychotropic medications – particularly, concentrating on plan enrollment and medication access.

B. Committee Activities

The committee members focused on two primary activities to accomplish its objectives – a survey of Community Mental Health Services Program (CMHSP) directors and an analysis of Part D enrollment trends for the dual eligibles.[7]

1. Part D Survey of Community Mental Health Services Programs (CMHSPs)

At their June 2006 meeting, committee members decided to poll directors of the forty-six CMHSPs to learn more about their clients' experiences during the transition period from Medicaid to Medicare prescription drug coverage. A workgroup of the committee's members developed questions (Appendix B) that were customized into an Internet-based survey instrument. The MSU Institute for Health Care Studies and the Michigan Association of Community Mental Health Boards sent invitations to the CMHSP directors for response.

Fifty-three responses were returned. Thirty-eight CMHSPs were identified. The responses provide a snapshot of the Part D experiences at the CMHSP level. Results, however, should not be considered *scientific* or *applicable statewide* because some programs sent multiple responses; some (thirteen responses) were sent anonymously; and other programs did not respond.

2. Part D Enrollment Trends for Dual Eligibles

Part D enrollment data from January 1 to June 30, 2006 – the first six months of the Medicare Part D program – was analyzed for Michigan dual eligibles. Committee members, also, requested data on psychotropic drug use for the dual eligibles prior to their transition from Medicaid to Medicare Part D prescription drug coverage. Key findings included:

- **Almost fifty percent of the dual eligibles in Michigan received psychotropic medications under the Medicaid program during the last six months of calendar 2005.** Of this population, thirty percent received one or more services from Community Mental

[7] MSU Institute for Health Care Studies staff collected and summarized responses from survey instrument developed by a workgroup of committee members. MSA staff also retrieved and analyzed enrollment data from the Michigan Medicaid Data Warehouse.

Health Service Programs (CMHSPs) and approximately 19 percent resided in nursing homes. Most dual eligibles enrolled during June 1, 2005 through December 31, 2005 were female (62 percent) as well as dual eligibles receiving psychotropic drugs (65 percent).

- **Over 204,400 Michigan dual eligibles are enrolled in Medicare prescription drug plans.** Michigan had 190,400 full-benefit and 14,000 Medicare Saving Programs dual eligibles [8] enrolled in Part D plans during June 2006. Of the full-benefit dual eligibles almost 95 percent were enrolled into stand-alone Part D prescription drugs plans offering zero premiums for dual eligibles (Table 3).

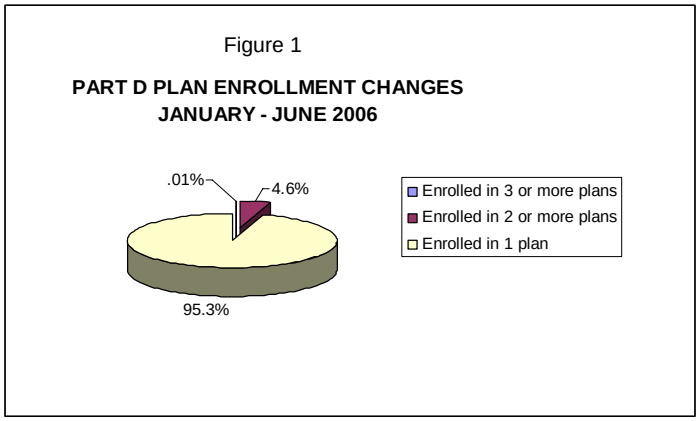
Table 3:
Full-Benefit Duals & Medicare Rx Enrollment, June 2006

Total Enrollment In Medicare Rx Plan	190,378
Enrollment In Stand-Alone Part D Plans Offering $0 Premium for Duals	179,986
Duals Not Enrolled In Medicare Rx Plan	2,563

- **During June 2006 about 2,600 full-benefit dual eligibles were not enrolled in a Medicare prescription drug plan** (Table 3). The volume of non-enrolled dual eligibles primarily includes individuals who are disabled and under age 65. Committee members noted that non-enrollment counts for the same month may fluctuate over time, because of retroactive Medicare eligibility; changes in credible other prescription drug insurance; CMS processing delays to assign dual eligibles a plan; and a federal policy that allows dual eligibles to switch Part D plans monthly. [As pointed out in the following section, this volume was a concern for committee members.]

- **The majority of dual eligibles did not switch Part D plans, even though CMS allows them to switch plans monthly. Approximately** half of the respondents to the committee's survey of Community Mental Health Services Programs believed that dual eligibles were switching plans to a moderate or substantial degree. The department's Part D enrollment data, however, showed that ninety-five percent remained in the same plan for the first six months of Part D's implementation (Figure 1). Of the dual eligibles switching from their CMS auto-assigned plan, about 9,800 individuals changed plans once; 200 individuals changed plans twice; and only two individuals changed three times. [Note: Individuals who switched plans will not be included in the 2007 CMS reassignment process, if their current plan is above the low-income subsidy benchmark by $2 or more.]

Figure 1



[8] Medicare Savings Programs are Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI-1) who receive coverage for Medicare premiums or cost-sharing, but no other Medicaid service. Under the Medicare Modernization Act, enrollees in Medicare Savings Programs qualified for auto-enrollment into Medicare Part D prescription drug coverage starting May 2006.

C. Committee Observations

The committee members made the following observations based upon their review of enrollment trends, CMHSP survey responses, their knowledge of Part D implementation issues, and firsthand experience working with dual eligibles.

- **The initial transition from Medicaid to Medicare Part D on January 1, 2006 was confusing for the dual eligibles (and their caregivers).** Nearly two-thirds of the CMHSP respondents indicated that dual eligibles understood their Part D benefits *a little or not at all*. Only one respondent commented that consumers understood the benefit well. Several respondents expressed concerns that the Part D coverage gap (the donut hole) would be a significant problem for dual eligibles when it is not applicable to them – indicating, perhaps, the respondents' desire to note a potential problem for non-dual eligibles; incorrect CMS coding issues; or misinformation on the Part D benefit for dual eligibles. About 79 percent of the respondents commented that dual eligibles received organizational assistance that aided them in understanding the Part D benefit. Many comments noted that pharmacies and staff of local CMHSPs, Michigan Medicare/Medicaid Assistance Program, area agencies on aging, and other organizations contributed countless hours helping the dual eligibles.
- **Although the transition from Medicaid to Medicare Part D for prescription drug coverage was confusing, dual eligibles overall obtained needed psychotropic medications – but access questions remain for some.** Over seventy percent of the respondents believed that the dual eligibles were receiving their mental health medications in a timely manner. About twenty-five percent believed this was not the case and another nearly five percent were unsure. Committee members noted some of the Medicare prescription drug plans did not comply with CMS requirements to pay the first-fill of a non-preferred drug (the transitional supply) – making it difficult for pharmacies and prescribers to coordinate prescription changes or request exceptions for coverage. Other members raised issues regarding unreasonable quantity limits set on psychotropic medications, necessitating that dual eligibles return to their pharmacies several times a month for refills. The dual eligibles, also, had to pay additional copayments for these refills that would not have occurred under the Medicaid prescription drug benefit.

  About 73 percent specified that prior authorization for mental health medications was *moderately* (49 percent) or *minimally* (24 percent) required by Part D plans, but 20 percent indicated prior authorization was *substantial*. Respondents noted that two-thirds of prior authorization requests made to Part D plans were approved. One commenter, however, listed the "[b]iggest problem is getting plans to approve [prior authorization requests] in a timely manner." Another indicated: "One of the most cumbersome barriers for us was not knowing when a consumer's medication needed a prior authorization."

  Fifty-eight percent noted *substantial* or *moderate* levels of exception requests to plans asking for reconsideration of their initial denied determination. Respondents reported 40 percent of the exception decisions were *pro-plan* (compared to 27 percent pro-consumer). One-third of the exception decisions were not reached in a timely manner (compared to an equal proportion that were deemed timely).

  The committee members observed that the variation in the respondents' experiences with prior authorization and exception requests likely is due to plan-to-plan differences in

policies for transitional supplies of non-covered drugs. Policies continue to vary, despite CMS guidance for conformity. These differences will likely remain during 2007 and beyond and will continue to provide challenges for the dual eligibles trying to obtain needed medications.

Appeals on denied prescriptions cannot be filed until exception redetermination requests are initiated. Thirty-six percent of the respondents indicated that the need to initiate appeals for denied prior authorizations was *minimal.* Some committee members reflected that it may be too early in the Part D program experience to gain a reasonable picture of appeals.

The survey also recorded complaints about out-of-pocket costs for the dual eligibles with over half of the respondents encountering a *moderate* to *substantial* level of complaints about the Part D copayments.

The level of mental health drug switching was most often viewed as *minimal* (49 percent) or *moderate* (29 percent), but nine percent rated it *substantial* with the remaining indicating unknown. Over a third of the respondents believed that the medications that the dual eligibles were switched to were less effective. Only three respondents, however, believed an inpatient psychiatric hospitalization resulted from dual eligibles switching from one psychotropic medication to another covered by the dual eligible's Part D plan.

- **After the initial transition from Medicaid to Medicare prescription drug coverage, major challenges center on navigating the multiple formularies, utilization controls, and prior authorization procedures of the various Part D plans.** One respondent wrote: "…it still is challenging to obtain timely and correct information regarding pricing and coverage. As well, because the formularies can change with very little notice, the program fails to provide stability in terms of coverage. Although the plans are required to provide a number of drugs in each class, this unfortunately does not ensure continuity or quality care – considering that some drugs simply do not provide the same benefit as others, and individuals respond differently, based on their own physiology, to drugs within the same class. The transition time for changing from the non-covered drug to the covered drug was in many cases a financial and clinical hardship for individuals."

  Another commented: "As many of the plans will cover only certain drugs, there has been a lot of 'plan switching' in order to locate a plan that will cover necessary drugs. This has been especially problematic for consumers who have had new/different medications added to their treatment regimen and/or consumers who have had medication changes due to side effects, poor response, etc."

- **Less than two percent of dual eligibles were not enrolled in Medicare Part D plans.** Both the survey and the enrollment trend analysis revealed that some dual eligibles (2,600 during June 2006) may not have been enrolled for Medicare prescription drug coverage. Some committee members noted that CMS has implemented a Point-Of-Sale (POS) Facilitated Process with Wellpoint to provide needed prescriptions to dual eligibles who are inadvertently not assigned a Part D plan. Members also commented that coding problems in federal databases may not correctly identify these individuals as eligible for Medicare and not auto-assign them a Part D plan. Others noted that the department's Part D enrollment counts may fluctuate for a particular month over time based on the update schedule of data received from CMS, retroactive Medicare eligibility, and other population changes. Also, dual eligibles that were not enrolled may have opted out of Part D, because they have credible prescription drug coverage from a private insurer. While these reasons may explain

why some dual eligibles appear to be not enrolled, the committee members, nonetheless, agreed the situation bears close scrutiny.

- **To assure that dual eligibles have access to needed medications, the department should continue to closely monitor the number of individuals who have not been enrolled in a Medicare prescription drug plan.** Source information may include information gathered from frontline service providers to data compiled from the department's Part D enrollment files provided and updated by CMS. The number of calls to the department's provider and beneficiary help lines on Part D prescription drug coverage may also serve as an early-warning system for problems dual eligibles are encountering. Although Michigan does not administer Part D, the state should have a strong interest in identifying and reducing the number of Michigan dual eligibles who qualify, but are not enrolled.

- **Most enhancements to the Part D coverages and its enrollment process discussed by the committee members cannot occur without statute changes to the Medicare Modernization Act of 2003.** The committee members believe that the following changes would be beneficial for dual eligibles. Most are, however, statutorily required in the Medicare Modernization Act of 2003 with the exception of CMS sharing Part D prescription drug data with the states. Several committee members suggested that the Michigan legislature may wish to investigate what authority, if any, it has to craft state legislation impacting these issues with the Part D program for dual eligibles.

  - **The process of choosing plan options and understanding procedures is a deterrent**. Simplified and standardized procedures among the Medicare Part D plans would enable dual eligibles to make more informed decisions to optimize their care.

  - **Some committee members believe CMS should consider limiting the frequency (currently permitted monthly) at which beneficiaries may change prescription drug plans. Others disagreed.** Continuity of care is an issue, since switching plans may not ensure that all prescriptions used by an individual are covered. Dual eligibles who switch between plans may also encounter coverage gaps and may be asked to pay prescriptions when their new plan is not posted to enrollment files used to process pharmacy claim requests.

    Other committee members disagreed stating that the flexibility to switch plans ensures that dual eligibles will be able to find a Medicare Part D plan that best meets their prescription needs.

  - **Cost-sharing amounts for dual eligibles should be lowered.** The federal government should lower copayments for dual eligibles. While the dollar amount is low, it is higher in some instances than Medicaid copayments and is problematic for this population with incomes close to subsistence levels. The MMA also indexes the Part D copayments amounts annually. Others noted that if dual eligibles lose their Medicaid eligibility during the course of a calendar year, they still maintain their Part D benefit – but must pay 100 percent for their benzodiazepine and for barbiturate prescriptions.

  - **CMS should provide sufficient controls to protect access to psychotropic drugs.** CMS should implement surveillance and accountability programs to ensure access to psychotropic medications for this vulnerable population. Particularly, CMS should review the quantity and frequency limits used by Part D plans.

- **CMS should closely monitor plan compliance with requirements related to the beneficiary appeals process.** CMS should take steps to implement procedures that are more "user friendly" for beneficiaries appealing denied coverage of a specific prescription drug. Plan adherence to the CMS required appeal steps and timeframes should be closely monitored. Several committee members, also, acknowledged procedures vary from plan-to-plan and that uniformity among plans would be desirable.
- **CMS should routinely share Part D prescription drug utilization with the states.** The committee members believed that lack of prescription drug data for the dual eligibles greatly inhibits the ability of the department to monitor the efficiency and effectiveness of the Part D plans and to evaluate health status changes of dual eligibles.

IV. CONCLUSION

The committee met from April to September 2006 – still relatively early after the January 1, 2006 implementation of Part D. As such, it is difficult to draw conclusions on the long term impact that Part D has on individuals prescribed psychotropic drugs. Following are key preliminary findings as concluded by the department's Medicare Part D Committee. The department should continue to monitor Part D issues through its available resources and current processes to ensure that Michigan dual eligibles have access to prescription drugs.

- While there were numerous implementation problems, currently the majority of dual eligibles are receiving their prescription drugs including psychotropic medications. Some questions remain about clinical appropriateness and use of utilization controls. The committee's survey of CMHSPs points to potential problems for a significant number of dual eligibles that received psychotropic drugs and these issues require further examination.
- Implementation problems were resolved, for the most part, due to the education, training, and networking efforts and to the individual assistance provided by Michigan agencies (especially Community Mental Health agency staff, the Medicare and Medicaid Assistance Program staff, and many volunteers), the Michigan Pharmacists Association, stakeholder organizations, legislative staff, and especially by the efforts of individual pharmacists and advocates.

APPENDIX A: COMMITTEE MEMBERS

Name	Organization
Rick Berchou, Pharm D, Chair	Wayne State University, Department of Psychiatry & Behavioral Neurosciences
Patrick Barrie	Mental Health and Substance Abuse Administration, MDCH
John Jokisch	Mental Health and Substance Abuse Administration, MDCH
Mark Reinstein	Mental Health Association in Michigan
Dave Lalumia	Michigan Association of Community Mental Health Boards
Greg Baran	Michigan Pharmacists Association
Karen Jonas	Michigan Pharmacists Association
Elmer Cerano	Michigan Protection and Advocacy Services
Laurel Isquith	Michigan Protection and Advocacy Services
Michelle Mull	Michigan Protection and Advocacy Services
Kathleen Gross	Michigan Psychiatric Society
Denise Holmes	Michigan State University Institute for Health Care Studies
John Hazewinkel	Michigan State University Institute for Health Care Studies
Tom McRae	Michigan State University Institute for Health Care Studies
Health Laird-Fick	Michigan State University, Department of Medicine
Judy Hutchins	National Alliance on Mental Illness of Michigan
Mary Johnson	Office for Services for the Aging, Michigan Medicare/Medicaid Assistance Program
Theresa Kidd	Office for Services for the Aging, Michigan Medicare/Medicaid Assistance Program
Neelam Puri	Office of Services to the Aging
Susan Moran	Medical Services Administration, MDCH
Giovannino Perri	Medical Services Administration, MDCH
Trish O'Keefe	Medical Services Administration, MDCH
Jacqueline Coleman	Medical Services Administration, MDCH

APPENDIX B: SURVEY INSTRUMENT

Dear CMHSP Executive Director:

Your experiences and views will significantly assist a legislatively established ad hoc committee that is reviewing the implementation of Medicare Part D psychotropic pharmacy administration for persons dually enrolled in Medicaid and Medicare (often referred to as "dual eligible" individuals).

The committee, which was enabled by Section 1628 of the Fiscal Year-06 DCH budget bill, is staffed by the Michigan Department of Community Health. Among its membership are representatives of MACMHB, Michigan Psychiatric Society, NAMI-Michigan, and the Mental Health Association.

The committee is gathering data and input toward preparation of a report that will be transmitted to the Legislature this fall. As part of such effort, the committee is surveying you and your colleagues across all CMHSPs for the valuable perspectives and information you can provide.

If you or your designee can take the ten minutes needed for responding to our survey, it would be greatly appreciated. The survey instrument can be completed below. If you prefer, a paper copy may be requested from John Hazewinkel at the MSU Institute for Health Care Studies. John is also available for any questions you have about this endeavor. He can be contacted at 517-432-7285 or John.Hazewinkel@hc.msu.edu.

All responses to our questionnaire will be treated confidentially and only used for purposes of contributing to overall, statewide summative data.

Thank you for your kind assistance in this important matter. We ask that you or your designee submit the completed survey by July 28, 2006. Your participation will help us in developing a picture of Part D enrollment and access trends for individuals who are dual Medicaid/Medicare and have mental health medication needs.

Sincerely,

Richard Berchou, Pharm. D.
Committee Chair

[Survey questions following]

Respondent

Information in this survey will be kept confidential, but we would like to have your name and contact information so we can make sure as many CMHSPs are represented as possible.

Name: _____

Title: _____

CMHSP: _____

I. General Information

1. How many dual-eligible consumers do you serve who are enrolled in a Medicare Part D plan? (Write "unknown" if you are unable to estimate.) _____

2. How many dual-eligible consumers do you serve who are NOT enrolled in a Medicare Part D plan? (Write "unknown" if you are unable to estimate.) _____

3. How well do your dual eligible customers understand their Part D benefit?
   □ Very well □ Somewhat □ A little □ Not at all □ Unknown/prefer not to answer

4. Did your dual-eligible consumers receive assistance from any organization in understanding their Part D benefit?
   □ Yes □ No □ Unknown/prefer not to answer

5. Please list any sources of information that were helpful to your dual-eligible consumers regarding understanding of their Part D benefit. (If you don't know please indicate.)
   Helpful _____

6. Please list any sources of information that were NOT helpful to your dual-eligible consumers regarding understanding of their Part D benefit. (If you don't know please indicate.)
   Not Helpful _____

II. Enrollment

1. In your opinion, have dual-eligible consumers been able to make informed decisions about whether or not to remain with their original Part D plan?
   □ Yes □ No □ Unknown/prefer not to answer

2. To what degree has your dual-eligible consumers switched Part D plans to obtain needed mental health drugs?
   □ Substantial □ Moderate □ Minimal □ Unknown/prefer not to answer

3. Please list any Part D plans that have been problematic for your dual-eligible consumers:
   _____

4. Please list any Part D plans that your dual-eligible consumers that have NOT been problematic for your dual-eligible consumers. _____

III. Mental Health Drug Coverage

1. Have your dual-eligible consumers received their mental health drugs in a timely manner under Part D?
   □ Yes □ No □ Unknown/prefer not to answer

2. The degree to which prior authorization has been required for your dual-eligible consumers' mental health drugs has been:
   □ Substantial □ Moderate □ Minimal □ Unknown/prefer not to answer

3. Most mental health prior authorization requests for your dual-eligible consumers have routinely been:
   □ Approved □ Denied □ Unknown/prefer not to answer

4. The degree to which mental health product exceptions have been requested of Part D plans for your dual-eligible consumers has been:
   □ Substantial □ Moderate □ Minima □ None □ Unknown/prefer not to answer

5. Exception decisions by Part D plans have primarily been (please check one):
   □ Timely and Pro-Consumer
   □ Timely but Pro-Part D Plan
   □ Lengthy and Pro-Consumer
   □ Lengthy and Pro-Part D Plan
   □ Unknown/prefer not to answer

6. The degree to which post-exception mental health product appeals have been filed by your dual-eligible consumers has been (please check one):
   □ Substantial □ Moderate □ Minimal □ None □ Unknown/prefer not to answer

7. Decisions on post-exception appeals filed by your dual-eligible consumers have primarily been:
   □ Timely and Pro-Consumer
   □ Timely but Pro-Part D Plan
   □ Lengthy and Pro-Consumer
   □ Lengthy and Pro-Part D Plan
   □ Unknown/prefer not to answer

8. Which categories of mental health drugs listed below have been problematic for your dual-eligible consumers to obtain under Medicare Part D? (Please check all that apply)
   □ Antipsychotics
   □ Antidepressants
   □ Bipolar agents
   □ Antianxiety
   □ Psychotropic injectables
   □ Other (Please list drug name) _____
   □ Unknown/prefer not to answer

9. The level of mental health drug-switching encountered under Part D by most of your dual-eligible consumers has been (please check one):
   □ Substantial □ Moderate □ Minimal □ Unknown/prefer not to answer

10. The mental health medications to which your dual-eligible consumers have been switched under Part D have primarily been (please check one):
    □ As effective □ Less effective □ Ineffective □ Unknown/prefer not to answer

11. Are you aware of any cases of inpatient psychiatric hospitalization as a result of mental drug switching and/or lack of continuity under Part D?(Please check one and if 'Yes' then indicate the # of cases)
    □ Yes □ No If "yes" please indicate the number of cases _____

12. The level of complaints you've encountered from dual-eligible consumers about Part D out-of-pocket costs has primarily been:
    □ Substantial □ Moderate □ Minimal □ None □ Unknown/prefer not to answer

IV. <u>Additional Comments</u>

Please write below or attach any narrative you wish to provide regarding Part D mental health drug coverage/access for consumers. Thank you for your kind assistance.